AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 4157, AS REPORTED

OFFERED BY M__. _____

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Information Technology Promotion Act of 2006''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. PRESERVING PRIVACY AND SECURITY LAWS.

Nothing in this Act (or the amendments made by this Act) shall be construed to affect the scope, substance, or applicability of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 and any regulation issued pursuant to such section.

TITLE I—COORDINATION FOR, PLANNING FOR, AND INTEROPERABILITY OF HEALTH INFORMATION TECHNOLOGY

SEC. 101. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

(a) IN GENERAL.—Title II of the Public Health Service Act is amended by adding at the end the following new part:

"PART D—HEALTH INFORMATION TECHNOLOGY

"SEC. 271. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY.

"(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an Office of the National Coordinator for Health Information Technology that shall be headed by the National Coordinator for Health Information Technology (referred to in this part as the 'National Coordinator'). The National Coordinator shall be appointed by and report directly to the Secretary. The National Coordinator shall be paid at a rate equal to the rate of basic pay for level IV of the Executive Schedule.

"(b) GOALS OF NATIONWIDE INTEROPERABLE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE.—The National Coordinator shall perform the du-

ties under subsection (c) in a manner consistent with the development of a nationwide interoperable health information technology infrastructure that—

''(1) improves health care quality, promotes data accuracy, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;

''(2) promotes wellness, disease prevention, and management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual for such individual;

''(3) promotes the availability of appropriate and accurate information necessary to make medical decisions in a usable form at the time and in the location that the medical service involved is provided;

''(4) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete or inaccurate information;

''(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, enhanced quality, and improved outcomes in health care services;

''(6) with respect to health information of consumers, advances the portability of such information and the ability of such consumers to share and use such information to assist in the management of their health care;

''(7) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health care information;

''(8) is consistent with legally applicable requirements with respect to securing and protecting the confidentiality of individually identifiable health information of a patient;

''(9) promotes the creation and maintenance of transportable, secure, Internet-based personal health records, including promoting the efforts of health care payers and health plan administrators for a health plan, such as Federal agencies, private health plans, and third party administrators, to provide for such records on behalf of members of such a plan;

''(10) promotes access to and review of the electronic health record of a patient by such patient;

''(11) promotes health research and health care quality research and assessment; and

''(12) promotes the efficient and streamlined development, submission, and maintenance of electronic health care clinical trial data.

''(c) DUTIES OF THE NATIONAL COORDINATOR.—

''(1) STRATEGIC PLANNER FOR INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.—The National Coordinator shall provide for a strategic plan for the nationwide implementation of interoperable health information technology in both the public and private health care sectors consistent with subsection (b).

''(2) PRINCIPAL ADVISOR TO THE SECRETARY.—The National Coordinator shall serve as the principal advisor to the Secretary on the development, application, and use of health information technology, and shall coordinate the policies and programs of the Department of Health and Human Services for promoting the use of health information technology.

''(3) INTRAGOVERNMENTAL COORDINATOR.—The National Coordinator shall ensure that health information technology policies and programs of the Department of Health and Human Services are coordinated with those of relevant executive branch agencies and departments with a goal to avoid dupli-

cation of effort, to align the health information architecture of each agency or department toward a common approach, to ensure that each agency or department conducts programs within the areas of its greatest expertise and its mission in order to create a national interoperable health information system capable of meeting national public health needs effectively and efficiently, and to assist Federal agencies and departments in security programs, policies, and protections to prevent unauthorized access to individually identifiable health information created, maintained, or in the temporary possession of that agency or department. The coordination authority provided to the National Coordinator under the previous sentence shall supercede any such authority otherwise provided to any other official of the Department of Health and Human Services. For the purposes of this paragraph, the term 'unauthorized access' means access that is not authorized by that agency or department including unauthorized employee access.

''(4) ADVISOR TO OMB.—The National Coordinator shall provide to the Director of the Office of Management and Budget comments and advice with

respect to specific Federal health information technology programs.

''(5) PROMOTER OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.—The National Coordinator shall—

''(A) identify sources of funds that will be made available to promote and support the planning and adoption of health information technology in medically underserved communities, including in urban and rural areas, either through grants or technical assistance;

''(B) coordinate with the funding sources to help such communities connect to identified funding; and

''(C) collaborate with the Agency for Healthcare Research and Quality and the Health Services Resources Administration and other Federal agencies to support technical assistance, knowledge dissemination, and resource development, to medically underserved communities seeking to plan for and adopt technology and establish electronic health information networks across providers.''.

(b) TREATMENT OF EXECUTIVE ORDER 13335.—Executive Order 13335 shall not have any force or effect after the date of the enactment of this Act.

(c) TRANSITION FROM ONCHIT UNDER EXECUTIVE ORDER.—

(1) IN GENERAL.—All functions, personnel, assets, liabilities, administrative actions, and statutory reporting requirements applicable to the old National Coordinator or the Office of the old National Coordinator on the date before the date of the enactment of this Act shall be transferred, and applied in the same manner and under the same terms and conditions, to the new National Coordinator and the Office of the new National Coordinator as of the date of the enactment of this Act.

(2) RULE OF CONSTRUCTION.— Nothing in this section or the amendment made by this section shall be construed as requiring the duplication of Federal efforts with respect to the establishment of the Office of the National Coordinator for Health Information Technology, regardless of whether such efforts are carried out before or after the date of the enactment of this Act.

(3) ACTING NATIONAL COORDINATOR.—Before the appointment of the new National Coordinator,

the old National Coordinator shall act as the National Coordinator for Health Information Technology until the office is filled as provided in section 271(a) of the Public Health Service Act, as added by subsection (a). The Secretary of Health and Human Services may appoint the old National Coordinator as the new National Coordinator.

(4) DEFINITIONS.—For purposes of this subsection:

(A) NEW NATIONAL COORDINATOR.—The term ''new National Coordinator'' means the National Coordinator for Health Information Technology appointed under section 271(a) of the Public Health Service Act, as added by subsection (a).

(B) OLD NATIONAL COORDINATOR.—The term ''old National Coordinator'' means the National Coordinator for Health Information Technology appointed under Executive Order 13335.

SEC. 102. REPORT ON THE AMERICAN HEALTH INFORMATION COMMUNITY.

Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the work

conducted by the American Health Information Community (in this section referred to as ''AHIC''), as established by the Secretary. Such report shall include the following:

(1) A description of the accomplishments of AHIC, with respect to the promotion of the development of national guidelines, the development of a nationwide health information network, and the increased adoption of health information technology.

(2) Information on how model privacy and security policies may be used to protect confidentiality of health information, and an assessment of how existing policies compare to such model policies.

(3) Information on the progress in—

(A) establishing uniform industry-wide health information technology standards;

(B) achieving an internet-based nationwide health information network;

(C) achieving interoperable electronic health record adoption across health care providers; and

(D) creating technological innovations to promote security and confidentiality of individually identifiable health information.

(4) Recommendations for the transition of AHIC to a longer-term or permanent advisory and facilitation entity, including—

(A) a schedule for such transition;

(B) options for structuring the entity as either a public-private or private sector entity;

(C) the collaberative role of the Federal Government in the entity;

(D) steps for—

(i) continued leadership in the facilitation of guidelines or standards;

(ii) the alignment of financial incentives; and

(iii) the long-term plan for health care transformation through information technology; and

(E) the elimination or revision of the functions of AHIC during the development of the nationwide health information network.

SEC. 103. INTEROPERABILITY PLANNING PROCESS; FEDERAL INFORMATION COLLECTION ACTIVITIES.

Part D of title II of the Public Health Service Act, as added by section 101(a), is amended by adding at the end the following new section:

"SEC. 272. INTEROPERABILITY PLANNING PROCESS; FEDERAL INFORMATION COLLECTION ACTIVITIES.

"(a) STRATEGIC INTEROPERABILITY PLANNING PROCESS.—

"(1) ASSESSMENT AND ENDORSEMENT OF CORE STRATEGIC GUIDELINES.—

"(A) IN GENERAL.—Not later than December 31, 2006, the National Coordinator shall publish a strategic plan, including a schedule, for the assessment and the endorsement of core interoperability guidelines for significant use cases consistent with this subsection. The National Coordinator may update such plan from time to time.

"(B) ENDORSEMENT.—

"(i) IN GENERAL.—Consistent with the schedule under this paragraph and not later than one year after the publication of such schedule, the National Coordinator shall endorse a subset of core interoperability guidelines for significant use cases. The National Coordinator shall continue to endorse subsets of core interoperability guidelines for significant use cases annually consistent with the schedule published

pursuant to this paragraph, with endorsement of all such guidelines completed not later than August 31, 2009.

''(ii) CONSULTATION.—All such endorsements shall be in consultation with the American Health Information Community and other appropriate entities.

''(iii) VOLUNTARY COMPLIANCE.—Compliance with such guidelines shall be voluntary, subject to subsection (b)(1).

''(C) CONSULTATION WITH OTHER PARTIES.—The National Coordinator shall develop and implement such strategic plan in consultation with the American Health Information Community and other appropriate entities.

''(D) DEFINITIONS.—For purposes of this section:

''(i) INTEROPERABILITY GUIDELINE.—The term 'interoperability guideline' means a guideline to improve and promote the interoperability of health information technology for purposes of electronically accessing and exchanging health information. Such term includes named standards, architectures, software schemes

for identification, authentication, and security, and other information needed to ensure the reproducible development of common solutions across disparate entities.

''(ii) CORE INTEROPERABILITY GUIDELINE.—The term 'core interoperability guideline' means an interoperability guideline that the National Coordinator determines is essential and necessary for purposes described in clause (i).

''(iii) SIGNIFICANT USE CASE.—The term 'significant use case' means a category (as specified by the National Coordinator) that identifies a significant use or purpose for the interoperability of health information technology, such as for the exchange of laboratory information, drug prescribing, clinical research, and electronic health records.

''(2) NATIONAL SURVEY.—

''(A) IN GENERAL.—Not later than August 31, 2008, the National Coordinator shall conduct one or more surveys designed to measure the capability of entities (including Federal agencies, State and local government agencies,

and private sector entities) to exchange electronic health information by appropriate significant use case. Such surveys shall identify the extent to which the type of health information, the use for such information, or any other appropriate characterization of such information may relate to the capability of such entities to exchange health information in a manner that is consistent with methods to improve the interoperability of health information and with core interoperability guidelines.

''(B) DISSEMINATION OF SURVEY RESULTS.—The National Coordinator shall disseminate the results of such surveys in a manner so as to—

''(i) inform the public on the capabilities of entities to exchange electronic health information;

''(ii) assist in establishing a more interoperable information architecture; and

''(iii) identify the status of health information systems used in Federal agencies and the status of such systems with respect to interoperability guidelines.

''(b) FEDERAL HEALTH INFORMATION COLLECTION ACTIVITIES.—

''(1) REQUIREMENTS.—With respect to a core interoperability guideline endorsed under subsection (a)(1)(B) for a significant use case, the President shall take measures to ensure that Federal activities involving the broad collection and submission of health information are consistent with such guideline within three years after the date of such endorsement.

''(2) PROMOTING USE OF NON-IDENTIFIABLE HEALTH INFORMATION TO IMPROVE HEALTH RESEARCH AND HEALTH CARE QUALITY.—

''(A) IN GENERAL.—Where feasible, and consistent with applicable privacy or security or other laws, the President, in consultation with the Secretary, shall take measures to allow timely access to useful categories of non-identifiable health information in records maintained by the Federal government, or maintained by entities under contract with the Federal government, to advance health care quality and health research where such information is in a form that can be used in such research. The President shall consult with appropriate Federal

agencies, and solicit public comment, on useful categories of information, and appropriate measures to take. The President may consider the administrative burden and the potential for improvements in health care quality in determining such appropriate measures. In addition, the President, in consultation with the Secretary, shall encourage voluntary private and public sector efforts to allow access to such useful categories of non-identifiable health information to advance health care quality and health research.

''(B) NON-IDENTIFIABLE HEALTH INFORMATION DEFINED.—For purposes of this paragraph, the term 'non-identifiable health information' means information that is not individually identifiable health information as defined in rules promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note), and includes information that has been de-identified so that it is no longer individually identifiable health information, as defined in such rules.

''(3) ANNUAL REVIEW AND REPORT.—For each year during the five-year period following the date of the enactment of this section, the National Coordinator shall review the operation of health information collection by and submission to the Federal government and the purchases (and planned purchases) of health information technology by the Federal government. For each such year and based on the review for such year, the National Coordinator shall submit to the President and Congress recommendations on methods to—

''(A) streamline (and eliminate redundancy in) Federal systems used for the collection and submission of health information;

''(B) improve efficiency in such collection and submission;

''(C) increase the ability to assess health care quality; and

''(D) reduce health care costs.''.

SEC. 104. GRANTS TO INTEGRATED HEALTH SYSTEMS TO PROMOTE HEALTH INFORMATION TECHNOLOGIES TO IMPROVE COORDINATION OF CARE FOR THE UNINSURED, UNDERINSURED, AND MEDICALLY UNDERSERVED.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"SEC. 330M. GRANTS FOR IMPROVEMENT OF THE COORDINATION OF CARE FOR THE UNINSURED, UNDERINSURED, AND MEDICALLY UNDERSERVED.

''(a) IN GENERAL.—The Secretary may make grants to integrated health care systems, in accordance with this section, for projects to better coordinate the provision of health care through the adoption of new health information technology, or the significant improvement of existing health information technology, to improve the provision of health care to uninsured, underinsured, and medically underserved individuals (including in urban and rural areas) through health-related information about such individuals, throughout such a system and at the point of service.

''(b) ELIGIBILITY.—

''(1) APPLICATION.—To be eligible to receive a grant under this section, an integrated health care system shall prepare and submit to the Secretary an

application, at such time, in such manner, and containing such information as the Secretary may require, including—

"(A) a description of the project that the system will carry out using the funds provided under the grant;

"(B) a description of the manner in which the project funded under the grant will advance the goal specified in subsection (a); and

"(C) a description of the populations to be served by the adoption or improvement of health information technology.

"(2) OPTIONAL REPORTING CONDITION.—The Secretary may also condition the provision of a grant to an integrated health care system under this section for a project on the submission by such system to the Secretary of a report on the impact of the health information technology adopted (or improved) under such project on the delivery of health care and the quality of care (in accordance with applicable measures of such quality). Such report shall be at such time and in such form and manner as specified by the Secretary.

"(c) INTEGRATED HEALTH CARE SYSTEM DEFINED.—For purposes of this section, the term 'integrated

health care system' means a system of health care providers that is organized to provide care in a coordinated fashion and has a demonstrated commitment to provide uninsured, underinsured, and medically underserved individuals with access to such care.

''(d) PRIORITIES.—In making grants under this section, the Secretary shall give priority to an integrated health care system—

''(1) that can demonstrate past successful community-wide efforts to improve the quality of care provided and the coordination of care for the uninsured, underinsured, and medically underserved; or

''(2) if the project to be funded through such a grant—

''(A) will improve the delivery of health care and the quality of care provided; and

''(B) will demonstrate savings for State or Federal health care benefits programs or entities legally obligated under Federal law to provide health care from the reduction of duplicative health care services, administrative costs, and medical errors.

''(e) LIMITATION, MATCHING REQUIREMENT, AND CONDITIONS.—

''(1) LIMITATION ON USE OF FUNDS.—None of the funds provided under a grant made under this section may be used for a project providing for the adoption or improvement of health information technology that is used exclusively for financial record keeping, billing, or other non-clinical applications.

''(2) MATCHING REQUIREMENT.—To be eligible for a grant under this section an integrated health care system shall contribute non-Federal contributions to the costs of carrying out the project for which the grant is awarded in an amount equal to $1 for each $5 of Federal funds provided under the grant.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2007 and 2008.''.

SEC. 105. SMALL PHYSICIAN PRACTICE DEMONSTRATION GRANTS.

Part D of title II of the Public Health Service Act, as added by section 101(a) and amended by section 103, is amended by adding at the end the following new section:

''SEC. 273. SMALL PHYSICIAN PRACTICE DEMONSTRATION GRANTS.

''(a) IN GENERAL.—The Secretary shall establish a demonstration program under which the Secretary makes

grants to small physician practices (including such practices that furnish services to individuals with chronic illnesses) that are located in rural areas or medically underserved urban areas for the purchase and support of health information technology.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, an applicant shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information, as the Secretary may require.

''(c) REPORTING.—

''(1) REQUIRED REPORTS BY SMALL PHYSICIAN PRACTICES.—A small physician practice receiving a grant under subsection (a) shall submit to the Secretary an evaluation on the health information technology funded by such grant. Such evaluation shall include information on—

''(A) barriers to the adoption of health information technology by the small physician practice;

''(B) issues for such practice in the use of health information technology;

''(C) the effect health information technology will have on the quality of health care furnished by such practice; and

''(D) the effect of any medical liability rules on such practice.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the results of the demonstration program under this section.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for each of fiscal years 2007 and 2008.''.

TITLE II—TRANSACTION STANDARDS, CODES, AND INFORMATION

SEC. 201. PROCEDURES TO ENSURE TIMELY UPDATING OF STANDARDS THAT ENABLE ELECTRONIC EXCHANGES.

Section 1174(b) of the Social Security Act (42 U.S.C. 1320d-3(b)) is amended—

(1) in paragraph (1)—

(A) in the first sentence, by inserting ''and in accordance with paragraph (3)'' before the period; and

(B) by adding at the end the following new sentence: ''For purposes of this subsection and section 1173(c)(2), the term 'modification' in-

cludes a new version or a version upgrade.''; and

(2) by adding at the end the following new paragraph:

''(3) EXPEDITED PROCEDURES FOR ADOPTION OF ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the Secretary shall provide for an expedited upgrade program (in this paragraph referred to as the 'upgrade program'), in accordance with this paragraph, to develop and approve additions and modifications to the standards adopted under section 1173(a) to improve the quality of such standards or to extend the functionality of such standards to meet evolving requirements in health care.

''(B) PUBLICATION OF NOTICES.—Under the upgrade program:

''(i) VOLUNTARY NOTICE OF INITIATION OF PROCESS.—Not later than 30 days after the date the Secretary receives a notice from a standard setting organization that the organization is initiating a process to develop an addition or modifica-

tion to a standard adopted under section 1173(a), the Secretary shall publish a notice in the Federal Register that—

''(I) identifies the subject matter of the addition or modification;

''(II) provides a description of how persons may participate in the development process; and

''(III) invites public participation in such process.

''(ii) VOLUNTARY NOTICE OF PRELIMINARY DRAFT OF ADDITIONS OR MODIFICATIONS TO STANDARDS.—Not later than 30 days after the date of the date the Secretary receives a notice from a standard setting organization that the organization has prepared a preliminary draft of an addition or modification to a standard adopted by section 1173(a), the Secretary shall publish a notice in the Federal Register that—

''(I) identifies the subject matter of (and summarizes) the addition or modification;

''(II) specifies the procedure for obtaining the draft;

''(III) provides a description of how persons may submit comments in writing and at any public hearing or meeting held by the organization on the addition or modification; and

''(IV) invites submission of such comments and participation in such hearing or meeting without requiring the public to pay a fee to participate.

''(iii) NOTICE OF PROPOSED ADDITION OR MODIFICATION TO STANDARDS.—Not later than 30 days after the date of the date the Secretary receives a notice from a standard setting organization that the organization has a proposed addition or modification to a standard adopted under section 1173(a) that the organization intends to submit under subparagraph (D)(iii), the Secretary shall publish a notice in the Federal Register that contains, with respect to the proposed addition or modification, the information required in

the notice under clause (ii) with respect to the addition or modification.

''(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring a standard setting organization to request the notices described in clauses (i) and (ii) with respect to an addition or modification to a standard in order to qualify for an expedited determination under subparagraph (C) with respect to a proposal submitted to the Secretary for adoption of such addition or modification.

''(C) PROVISION OF EXPEDITED DETERMINATION.—Under the upgrade program and with respect to a proposal by a standard setting organization for an addition or modification to a standard adopted under section 1173(a), if the Secretary determines that the standard setting organization developed such addition or modification in accordance with the requirements of subparagraph (D) and the National Committee on Vital and Health Statistics recommends approval of such addition or modification under subparagraph (E), the Secretary

shall provide for expedited treatment of such proposal in accordance with subparagraph (F).

''(D) REQUIREMENTS.—The requirements under this subparagraph with respect to a proposed addition or modification to a standard by a standard setting organization are the following:

''(i) REQUEST FOR PUBLICATION OF NOTICE.—The standard setting organization submits to the Secretary a request for publication in the Federal Register of a notice described in subparagraph (B)(iii) for the proposed addition or modification.

''(ii) PROCESS FOR RECEIPT AND CONSIDERATION OF PUBLIC COMMENT.—The standard setting organization provides for a process through which, after the publication of the notice referred to under clause (i), the organization—

''(I) receives and responds to public comments submitted on a timely basis on the proposed addition or modification before submitting such proposed addition or modification to

the National Committee on Vital and Health Statistics under clause (iii);

''(II) makes publicly available a written explanation for its response in the proposed addition or modification to comments submitted on a timely basis; and

''(III) makes public comments received under clause (I) available, or provides access to such comments, to the Secretary.

''(iii) SUBMITTAL OF FINAL PROPOSED ADDITION OR MODIFICATION TO NCVHS.—After completion of the process under clause (ii), the standard setting organization submits the proposed addition or modification to the National Committee on Vital and Health Statistics for review and consideration under subparagraph (E). Such submission shall include information on the organization's compliance with the notice and comment requirements (and responses to those comments) under clause (ii).

"(E) HEARING AND RECOMMENDATIONS BY NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Under the upgrade program, upon receipt of a proposal submitted by a standard setting organization under subparagraph (D)(iii) for the adoption of an addition or modification to a standard, the National Committee on Vital and Health Statistics shall provide notice to the public and a reasonable opportunity for public testimony at a hearing on such addition or modification. The Secretary may participate in such hearing in such capacity (including presiding ex officio) as the Secretary shall determine appropriate. Not later than 120 days after the date of receipt of the proposal, the Committee shall submit to the Secretary its recommendation to adopt (or not adopt) the proposed addition or modification.

"(F) DETERMINATION BY SECRETARY TO ACCEPT OR REJECT NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS RECOMMENDATION.—

"(i) TIMELY DETERMINATION.—Under the upgrade program, if the National Committee on Vital and Health Sta-

tistics submits to the Secretary a recommendation under subparagraph (E) to adopt a proposed addition or modification, not later than 90 days after the date of receipt of such recommendation the Secretary shall make a determination to accept or reject the recommendation and shall publish notice of such determination in the Federal Register not later than 30 days after the date of the determination.

''(ii) CONTENTS OF NOTICE.—If the determination is to reject the recommendation, such notice shall include the reasons for the rejection. If the determination is to accept the recommendation, as part of such notice the Secretary shall promulgate the modified standard (including the accepted proposed addition or modification accepted) as a final rule under this subsection without any further notice or public comment period.

''(iii) LIMITATION ON CONSIDERATION.—The Secretary shall not consider a proposal under this subparagraph unless the Secretary determines that the require-

ments of subparagraph (D) (including publication of notice and opportunity for public comment) have been met with respect to the proposal.

''(G) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to a final rule promulgated under subparagraph (F).

''(H) TREATMENT AS SATISFYING REQUIREMENTS FOR NOTICE-AND-COMMENT.—Any requirements under section 553 of title 5, United States Code, relating to notice and an opportunity for public comment with respect to a final rule promulgated under subparagraph (F) shall be treated as having been met by meeting the requirements of the notice and opportunity for public comment provided under provisions of subparagraphs (B)(iii), (D), and (E).

''(I) NO JUDICIAL REVIEW.—A final rule promulgated under subparagraph (F) shall not be subject to judicial review.''.

SEC. 202. UPGRADING ASC X12 AND NCPDP STANDARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide by notice published in the

Federal Register for the following replacements of standards to apply to transactions occurring on or after April 1, 2009:

(1) ACCREDITED STANDARDS COMMITTEE X12 (ASC X12) STANDARD.—The replacement of the Accredited Standards Committee X12 (ASC X12) version 4010 adopted under section 1173(a) of such Act (42 U.S.C. 1320d-2(a)) with the ASC X12 version 5010, as reviewed by the National Committee on Vital Health Statistics.

(2) NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP) TELECOMMUNICATIONS STANDARDS.—The replacement of the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standards version 5.1 adopted under section 1173(a) of such Act (42 U.S.C. 1320d-2(a)) with whichever is the latest version of the NCPDP Telecommunications Standards that has been approved by such Council and reviewed by the National Committee on Vital Health Statistics as of April 1, 2007.

(b) NO JUDICIAL REVIEW.—The implementation of subsection (a), including the determination of the latest version under subsection (a)(2), shall not be subject to judicial review.

SEC. 203. UPGRADING ICD CODES; CODING AND DOCUMENTATION OF NON-MEDICAL INFORMATION.

(a) UPGRADING ICD CODES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide by notice published in the Federal Register for the replacement of the International Classification of Diseases, 9th revision, Clinical Modification (ICD–9-CM) under the regulation promulgated under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)), including for purposes of part A of title XVIII of such Act, with both of the following:

(A) The International Classification of Diseases, 10th revision, Clinical Modification (ICD–10-CM).

(B) The International Classification of Diseases, 10th revision, Procedure Coding System (ICD–10-PCS).

(2) APPLICATION.—The replacement made by paragraph (1) shall apply, for purposes of section 1175(b)(2) of the Social Security Act (42 U.S.C. 1320d-4(b)(2)), to services furnished on or after October 1, 2010.

(3) RULES OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) as affecting the application of classification methodologies or codes, such as CPT or HCPCS codes, other than under the International Classification of Diseases (ICD); or

(B) as superseding the authority of the Secretary of Health and Human Services to maintain and modify the coding set for ICD–10-CM and ICD–10-PCS, including under the amendments made by section 201.

(b) CODING AND DOCUMENTATION OF NON-MEDICAL INFORMATION.—In any regulation or other action implementing the International Classification of Diseases, 10th revision, Clinical Modification (ICD–10-CM), the International Classification of Diseases, 10th revision, Procedure Coding System (ICD–10-PCS), or other version of the International Classification of Diseases, 10th revision, the Secretary of Health and Human Services shall ensure that no health care provider is required to code to a level of specificity that would require documentation of non-medical information on the external cause of any given type of injury.

SEC. 204. STRATEGIC PLAN FOR COORDINATING IMPLEMENTATION OF TRANSACTION STANDARDS AND ICD CODES.

Not later than the date that is 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with relevant public and private entities, shall develop a strategic plan with respect to the need for coordination in the implementation of—

(1) transaction standards under section 1173(a) of the Social Security Act, including modifications to such standards under section 1174(b)(3) of such Act, as added by section 201; and

(2) any updated versions of the International Classification of Diseases (ICD), including the replacement of ICD–9 provided for under section 203(a).

SEC. 205. STUDY AND REPORT TO DETERMINE IMPACT OF VARIATION AND COMMONALITY IN STATE HEALTH INFORMATION LAWS AND REGULATIONS.

Part C of title XI of the Social Security Act is amended by adding at the end the following new section:

''STUDY AND REPORT TO DETERMINE IMPACT OF VARIATION AND COMMONALITY IN STATE HEALTH INFORMATION LAWS AND REGULATIONS

''SEC. 1180. (a) STUDY.—For purposes of promoting the development of a nationwide interoperable health information technology infrastructure consistent with section 271(b) of the Public Health Service Act, the Secretary shall conduct a study of the impact of variation in State security and confidentiality laws and current Federal security and confidentiality standards on the timely exchanges of health information in order to ensure the availability of health information necessary to make medical decisions at the location in which the medical care involved is provided. Such study shall examine—

''(1)(A) the degree of variation and commonality among the requirements of such laws for States; and

''(B) the degree of variation and commonality between the requirements of such laws and the current Federal standards;

''(2) insofar as there is variation among and between such requirements, the strengths and weaknesses of such requirements; and

''(3) the extent to which such variation may adversely impact the secure, confidential, and timely

exchange of health information among States, the Federal government, and public and private entities, or may otherwise impact the reliability of such information.

''(b) REPORT.—Not later than 18 months after the date of the enactment of this section, the Secretary shall submit to Congress a report on the study under subsection (a) and shall include in such report the following:

''(1) ANALYSIS OF NEED FOR GREATER COMMONALITY.—A determination by the Secretary on the extent to which there is a need for greater commonality of the requirements of State security and confidentiality laws and current Federal security and confidentiality standards to better protect, strengthen, or otherwise improve the secure, confidential, and timely exchange of health information among States, the Federal government, and public and private entities.

''(2) RECOMMENDATIONS FOR GREATER COMMONALITY.—Insofar as the Secretary determines under paragraph (1) that there is a need for greater commonality of such requirements, recommendations on the extent to which (and how) the current Federal security and confidentiality standards should be changed in order to provide the commonality needed

to better protect, strengthen, or otherwise improve the secure, confidential, and timely exchange of health information.

''(3) SPECIFIC RECOMMENDATION ON LEGISLATIVE CHANGES FOR GREATER COMMONALITY.—A specific recommendation on the extent to which and how such standards should supersede State laws, in order to provide the commonality needed to better protect or strengthen the security and confidentiality of health information in the timely exchange of such information and legislative language in the form of a bill to effectuate such specific recommendation.

''(c) CONGRESSIONAL CONSIDERATION OF LEGISLATION PROVIDING FOR GREATER COMMONALITY.—

''(1) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This subsection is enacted by the Congress—

''(A) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such they are deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a greater commonality bill defined in paragraph (4), and they supersede other

rules only to the extent that they are inconsistent therewith; and

''(B) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

''(2) INTRODUCTION.—On the date on which the final report is submitted under subsection (b)(3)—

''(A) a greater commonality bill shall be introduced (by request) in the House by the majority leader of the House, for himself and the minority leader of the House, or by Members of the House designated by the majority leader and minority leader of the House; and

''(B) a greater commonality bill shall be introduced (by request) in the Senate by the majority leader of the Senate, for himself and the minority leader of the Senate, or by Members of the Senate designated by the majority leader and minority leader of the Senate.

If either House is not in session on the day on which such a report is submitted, the greater commonality

bill shall be introduced in that House, as provided in the preceding sentence, on the first day thereafter on which the House is in session.

''(3) REFERRAL.—A greater commonality bill shall be referred by the Presiding Officers of the respective House to the appropriate committee (or committees) of such House, in accordance with the rules of that House.

''(4) GREATER COMMONALITY BILL DEFINED.—For purposes of this section, the term 'greater commonality bill' means a bill—

''(A) the title of which is the following: 'A Bill to provide the commonality needed to better protect, strengthen, or otherwise improve the secure, confidential, and timely exchange of health information'; and

''(B) the text of which, as introduced, consists of the text of the bill included in the report submitted under subsection (b)(3).

''(d) DEFINITIONS.—For purposes of this section:

''(1) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS.—The term 'current Federal security and confidentiality standards' means the Federal privacy standards established pursuant to section 264(c) of the Health Insurance Portability

and Accountability Act of 1996 (42 U.S.C. 1320d-2 note) and security standards established under section 1173(d) of the Social Security Act.

''(2) STATE.—The term 'State' has the meaning given such term when used in title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

''(3) STATE SECURITY AND CONFIDENTIALITY LAWS.—The term 'State security and confidentiality laws' means State laws and regulations relating to the privacy and confidentiality of health information or to the security of such information.''.

TITLE III—PROMOTING THE USE OF HEALTH INFORMATION TECHNOLOGY TO BETTER COORDINATE HEALTH CARE

SEC. 301. SAFE HARBORS TO ANTIKICKBACK CIVIL PENALTIES AND CRIMINAL PENALTIES FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES.

(a) FOR CIVIL PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(4) For purposes of this subsection, inducements to reduce or limit services described in paragraph (1) shall not include the practical or other advantages resulting from health information technology or related installation, maintenance, support, or training services.''; and

(2) in subsection (i), by adding at the end the following new paragraph:

''(8) The term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.''.

(b) FOR CRIMINAL PENALTIES.—Section 1128B of such Act (42 U.S.C. 1320a-7b) is amended—

(1) in subsection (b)(3)—

(A) in subparagraph (G), by striking ''and'' at the end;

(B) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2213)—

(i) by moving such subparagraph 2 ems to the left; and

(ii) by striking the period at the end and inserting a semicolon;

(C) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(i) by redesignating such subparagraph as subparagraph (I);

(ii) by moving such subparagraph 2 ems to the left; and

(iii) by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following new subparagraph:

''(J) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(i)(8), or related installation, maintenance, support or training services) made to a person by a specified entity (as defined in subsection (g)) if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services

provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration solicited or received (or offered or paid) and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity providing the remuneration (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.''; and

(2) by adding at the end the following new subsection:

''(g) SPECIFIED ENTITY DEFINED.—For purposes of subsection (b)(3)(J), the term 'specified entity'—

''(1) means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology; and

''(2) includes, effective October 1, 2011, any entity.''.

(c) EFFECTIVE DATE AND EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction de-

scribed in section 1128A(b)(4) or section 1128B(b)(3)(J) of such Act, as added by subsections (a)(1) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(d) STUDY AND REPORT TO ASSESS EFFECT OF SAFE HARBORS ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors described in paragraph (3). In particular, the study shall examine the following:

(A) The effectiveness of each safe harbor in increasing the adoption of health information technology.

(B) The types of health information technology provided under each safe harbor.

(C) The extent to which the financial or other business relationships between providers under each safe harbor have changed as a result of the safe harbor in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under each safe harbor.

(2) REPORT.—Not later than three years after the effective date described in subsection (c)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

(3) SAFE HARBORS DESCRIBED.—For purposes of paragraphs (1) and (2), the safe harbors described in this paragraph are—

(A) the safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a-7a(b)(4)), as added by subsection (a)(1); and

(B) the safe harbor under section 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a-7b(b)(3)(J)), as added by subsection (b).

SEC. 302. EXCEPTION TO LIMITATION ON CERTAIN PHYSICIAN REFERRALS (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

''(6) INFORMATION TECHNOLOGY AND TRAINING SERVICES.—

''(A) IN GENERAL.—Any nonmonetary remuneration (in the form of health information technology or related installation, maintenance, support or training services) made by a specified entity to a physician if—

''(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

''(I) limits or restricts the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

''(II) limits or restricts the use of the health information technology in conjunction with other health information technology; or

''(III) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

''(ii) such remuneration is arranged for in a written agreement that is signed

by the parties involved (or their representatives) and that specifies the remuneration made and states that the provision of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

''(iii) the specified entity (or a representative of such entity) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would permit interoperability.

''(B) HEALTH INFORMATION TECHNOLOGY DEFINED.—For purposes of this paragraph, the term 'health information technology' means hardware, software, license, right, intellectual property, equipment, or other information technology (including new versions, upgrades, and connectivity) designed or provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.

"(C) SPECIFIED ENTITY DEFINED.—For purposes of this paragraph, the term 'specified entity'—

"(i) means an entity that is a hospital, group practice, prescription drug plan sponsor, a Medicare Advantage organization, or any other such entity specified by the Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology; and

"(ii) includes, effective October 1, 2011, any entity.".

(b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1301(a)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction de-

scribed in section 1877(b)(6) of such Act, as added by subsection (a), if the conditions described in such section, with respect to such transaction, are met.

(c) STUDY AND REPORT TO ASSESS EFFECT OF EXCEPTION ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of the exception under section 1877(b)(6) of such Act (42 U.S.C. 1395nn(b)(6)), as added by subsection (a). In particular, the study shall examine the following:

(A) The effectiveness of the exception in increasing the adoption of health information technology.

(B) The types of health information technology provided under the exception.

(C) The extent to which the financial or other business relationships between providers under the exception have changed as a result of the exception in a way that adversely affects or benefits the health care system or choices available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under the exception.

(2) REPORT.—Not later than three years after the effective date described in subsection (b)(1), the Secretary of Health and Human Services shall submit to Congress a report on the study under paragraph (1).

SEC. 303. RULES OF CONSTRUCTION REGARDING USE OF CONSORTIA.

(a) APPLICATION TO SAFE HARBOR FROM CRIMINAL PENALTIES.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a-7b(b)(3)) is amended by adding after and below subparagraph (J), as added by section 301(b)(1), the following:''For purposes of subparagraph (J), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology, or from offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

(b) APPLICATION TO STARK EXCEPTION.—Paragraph (6) of section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)), as added by section 302(a), is

amended by adding at the end the following new subparagraph:

''(D) RULE OF CONSTRUCTION.—For purposes of subparagraph (A), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from—

''(i) forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology; or

''(ii) offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.''.

TITLE IV—ADDITIONAL PROVISIONS

SEC. 401. PROMOTION OF TELEHEALTH SERVICES.

(a) FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.—The Secretary of Health and Human Services shall, in coordination with physicians, health care practitioners, patient advocates, and representatives of States, encourage and facilitate the

adoption of State reciprocity agreements for practitioner licensure in order to expedite the provision across State lines of telehealth services.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the actions taken to carry out subsection (a).

(c) STATE DEFINED.—For purposes of this subsection, the term ''State'' has the meaning given that term for purposes of title XVIII of the Social Security Act.

SEC. 402. STUDY AND REPORT ON EXPANSION OF HOME HEALTH-RELATED TELEHEALTH SERVICES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine the feasibility, advisability, and the costs of—

(1) including coverage and payment for home health-related telehealth services as part of home health services under title XVIII of the Social Security Act; and

(2) expanding the list of sites described in paragraph (4)(C)(ii) of section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) to include county mental health clinics or other publicly funded mental health facilities for the purpose of payment under

such section for the provision of telehealth services at such clinics or facilities.

(b) SPECIFICS OF STUDY.—Such study shall demonstrate whether the changes described in paragraphs (1) and (2) of subsection (a) will result in the following:

(1) Enhanced health outcomes for individuals with one or more chronic conditions.

(2) Health outcomes for individuals furnished telehealth services or home health-related telehealth services that are at least comparable to the health outcomes for individuals furnished similar items and services by a health care provider at the same location of the individual or at the home of the individual, respectively.

(3) Facilitation of communication of more accurate clinical information between health care providers.

(4) Closer monitoring of individuals by health care providers.

(5) Overall reduction in expenditures for health care items and services.

(6) Improved access to health care.

(c) HOME HEALTH-RELATED TELEHEALTH SERVICES DEFINED.—For purposes of this section, the term ''home health-related telehealth services'' means tech-

nology-based professional consultations, patient monitoring, patient training services, clinical observation, patient assessment, and any other health services that utilize telecommunications technologies. Such term does not include a telecommunication that consists solely of a telephone audio conversation, facsimile, electronic text mail, or consultation between two health care providers.

(d) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a) and shall include in such report such recommendations for legislation or administration action as the Secretary determines appropriate.

SEC. 403. STUDY AND REPORT ON STORE AND FORWARD TECHNOLOGY FOR TELEHEALTH.

(a) STUDY.—The Secretary of Health and Human Services, acting through the Director of the Office for the Advancement of Telehealth, shall conduct a study on the use of store and forward technologies (that provide for the asynchronous transmission of health care information in single or multimedia formats) in the provision of telehealth services. Such study shall include an assessment of the feasibility, advisability, and the costs of expanding the

use of such technologies for use in the diagnosis and treatment of certain conditions.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a) and shall include in such report such recommendations for legislation or administration action as the Secretary determines appropriate.

SEC. 404. METHODOLOGY FOR REPORTING UNIFORM PRICE DATA FOR INPATIENT AND OUTPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall develop a method for the reporting of uniform price data for inpatient and outpatient hospital services. Such method shall provide for the reporting by each hospital of such data for selected procedures or services based on a range of charges and a range of prices actually paid for inpatient and outpatient hospital services grouped by type of payer, with each of the following treated as a separate type of payer: the Medicare program, the Medicaid program, other public health insurance coverage (including public group health plan coverage), private health insurance coverage (including private group health plan coverage), other insurance coverage, and self-pay.

(b) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to assess the structure and methodology for permanent uniform reporting of price data for health care services.

(2) REPORT.—Not later than January 1, 2008, the Comptroller General shall submit to Congress a report on the study under paragraph (1). Such report shall include the following:

(A) Recommendations on a structure and methodology, for timely reporting of charges and prices actually paid for health care services, that minimize administrative requirements for providers and maximize efficient reporting utilizing health information technology.

(B) Options for facilitating public disclosure of such information in a manner accessible and useful to consumers.

(C) Review of the strengths and weaknesses of the reporting requirements imposed beginning with fiscal year 2008 under section 405.

SEC. 405. INCLUSION OF UNIFORM PRICE DATA.

Data required to be submitted pursuant to section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C.

1395ww(b)(3)(B)(viii)) shall include, effective with fiscal year 2008, the data described in section 404(a), with respect to inpatient hospital services, submitted in accordance with the method developed under such section, as well as the aggregate volume of selected procedures or services for which the data are reported.

SEC. 406. ENSURING HEALTH CARE PROVIDERS PARTICIPATING IN PHSA PROGRAMS, MEDICAID, SCHIP, OR THE MCH PROGRAM MAY MAINTAIN HEALTH INFORMATION IN ELECTRONIC FORM.

Part D of title II of the Public Health Service Act, as added by section 101(a) and amended by sections 103 and 105, is further amended by adding at the end the following new section:

"SEC. 274. ENSURING HEALTH CARE PROVIDERS MAY MAINTAIN HEALTH INFORMATION IN ELECTRONIC FORM.

''(a) IN GENERAL.—Any health care provider that participates in a health care program that receives Federal funds under this Act, or under title V, XIX, or XXI of the Social Security Act, shall be deemed as meeting any requirement for the maintenance of data in paper form under such program (whether or not for purposes of man-

agement, billing, reporting, reimbursement, or otherwise) if the required data is maintained in an electronic form.

''(b) RELATION TO STATE LAWS.—Beginning on the date that is one year after the date of the enactment of this section, subsection (a) shall supersede any contrary provision of State law.

''(c) CONSTRUCTION.—Nothing in this section shall be construed as—

''(1) requiring health care providers to maintain or submit data in electronic form;

''(2) preventing a State from permitting health care providers to maintain or submit data in paper form; or

''(3) preventing a State from requiring health care providers to maintain or submit data in electronic form.''.

SEC. 407. ENSURING HEALTH CARE PROVIDERS PARTICIPATING IN THE MEDICARE PROGRAM MAY MAINTAIN HEALTH INFORMATION IN ELECTRONIC FORM.

Section 1871 of the Social Security Act (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(g)(1) Any provider of services or supplier shall be deemed as meeting any requirement for the maintenance

of data in paper form under this title (whether or not for purposes of management, billing, reporting, reimbursement, or otherwise) if the required data is maintained in an electronic form.

''(2) Nothing in this subsection shall be construed as requiring health care providers to maintain or submit data in electronic form.''.

SEC. 408. STUDY AND REPORT ON STATE, REGIONAL, AND COMMUNITY HEALTH INFORMATION EXCHANGES.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on issues related to the development, operation, and implementation of State, regional, and community health information exchanges. Such study shall include the following, with respect to such health information exchanges:

(1) Profiles detailing the current stages of such health information exchanges with respect to the progression of the development, operation, implementation, organization, and governance of such exchanges.

(2) The impact of such exchanges on healthcare quality, safety, and efficiency, including—

(A) any impact on the coordination of health information and services across

healthcare providers and other organizations relevant to health care;

(B) any impact on the availability of health information at the point-of-care to make timely medical decisions;

(C) any benefits with respect to the promotion of wellness, disease prevention, and chronic disease management;

(D) any improvement with respect to public health preparedness and response;

(E) any impact on the widespread adoption of interoperable health information technology, including electronic health records;

(F) any contributions to achieving an Internet-based national health information network;

(G) any contribution of health information exchanges to consumer access and to consumers' use of their health information; and

(H) any impact on the operation of—

(i) the Medicaid and Medicare programs;

(ii) the State Children's Health Insurance Program (SCHIP);

(iii) disproportionate share hospitals described in section 1923 of the Social Security Act;

(iv) Federally-qualified health centers; or

(v) managed care plans, if a significant number of the plan's enrollees are beneficiaries in the Medicaid program or SCHIP.

(3) Best practice models for financing, incentivizing, and sustaining such health information exchanges.

(4) Information identifying the common principles, policies, tools, and standards used (or proposed) in the public and private sectors to support the development, operation, and implementation of such health information exchanges.

(5) A description of any areas in which Federal government leadership is needed to support growth and sustainability of such health information exchanges.

(b) REPORT.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study described in subsection (a), including such rec-

ommendations as the Secretary determines appropriate to facilitate the development, operation, and implementation of health information exchanges.

Amend the title so as to read: ''A Bill to promote a better health information system.''.